
**CRITICAL CONCERNS AND CHALLENGES IN NEPHROLOGY SOCIAL WORK PRACTICE:
REACTIONS TO THE 2008 CONDITIONS FOR COVERAGE**

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This qualitative study examined the written comments provided by 406 nephrology social workers who responded to an online survey conducted in 2010 by the Council of Nephrology Social Workers (CNSW). Data were analyzed using a constant comparative method to identify themes that highlight concerns and challenges related to day-to-day practice in renal settings. Findings yielded four primary themes associated with the implementation of the 2008 Medicare and Medicaid Program Conditions for Coverage for End-Stage Renal Disease Facilities: increased paperwork expectations, loss of patient contact, workload demands, and job dissatisfaction. Implications for nephrology social work practice and research are discussed.

Nephrology social workers provide essential psychosocial services to patients with end-stage renal disease (Browne, 2006; Dobrof, Dolinko, Lichtiger, Uribarri, & Epstein, 2001; McKinley & Callahan, 1998; McKinley, Schrag, & Dobrof, 2000; Merighi & Ehlebracht, 2004a, 2004b, 2004c; Wolfe, 2011). These services include patient and family education, supportive counseling, crisis intervention, provision of information and community referrals, interdisciplinary care planning and collaboration, and patient advocacy (Dobrof et al., 2001; McKinley & Callahan, 1998; McKinley et al., 2000; Merighi & Ehlebracht, 2004a, 2004b, 2004c; Russo, 2002). For some patients, one debilitating consequence of end-stage renal disease is clinical depression (Cukor, Peterson, Cohen, & Kimmel, 2006), which in turn can affect treatment adherence and self-management (Browne & Merighi, 2010; Cukor, Rosenthal, Jindal, Brown, & Kimmel, 2009), quality of life (Mapes et al., 2004), and mortality and hospitalization (Lowrie, Curtin, LePain, & Schatell, 2003). Social work interventions are an important component of overall patient care, especially in regard to the identification and treatment of mental health issues that are often associated with end-stage renal disease. Studies have documented the positive effect that social work interventions such as counseling and education have on patients' psychological well-being and on their psychosocial adjustment (Beder, 1999; Dobrof et al., 2001). Recently, a study of nephrology social workers who implemented a brief symptom-targeted intervention (STI) to ameliorate depression in dialysis patients achieved a 72% improvement in patients' Center for Epidemiological Studies—Depression (CES-D) summary score between pre- and post-treatment (McCool et al., 2011; Sledge et al., 2011). Interventions such as the STI provide evidence of how nephrology social workers can be instrumental in treating their patients' mental health symptoms and improving their health outcomes.

To assist patients with end-stage renal disease effectively and skillfully, nephrology social workers must have adequate time and resources to provide those patients with mandated psychosocial support services. This has become particularly important since the implementation of the 2008 Medicare and Medicaid Program Conditions for Coverage for End-Stage Renal Disease Facilities (CfC) (Federal Register, 2008). Social work practitioners employed in nephrology settings possess specialized knowledge and skills that equip them to address the psychological and emotional aspects of the disease process (Browne, 2006). However, this specialized knowledge is not used to full advantage when their patient caseloads are high and their day-to-day responsibilities include an overemphasis on clerical duties, arranging patient transportation and travel, dealing with billing issues, and verifying patients' insurance. Previous research has documented the prevalence and burden associated with non-clinical tasks that are not commensurate with the formal training of master's level social workers (Merighi & Ehlebracht, 2002, 2004a, 2004b, 2004c, 2005). In particular, job-related emotional exhaustion was negatively associated with providing clinical counseling to patients and positively associated with performing clerical and insurance tasks (Merighi & Ehlebracht, 2005). High caseloads can prevent nephrology social workers from providing adequate clinical services to their patients (Merighi & Ehlebracht, 2002). Between 2007 and 2010, outpatient dialysis social workers in the United States experienced increases in mean caseload size from 73 to 79 (up 8.2%) for those employed 20 to 31 hours per week, 113 to 121 (up 7.1%) for those employed 32 to 40 hrs/wk, and 117 to 126 (up 7.7%) for those employed 40 hrs/wk (Merighi, Browne, & Bruder, 2010). These striking increases in patient caseloads and the burdens linked to performing a disproportionate amount of non-clinical tasks in nephrology settings underscore the need to examine the experiences of nephrology social workers since the implementation of the 2008 CfC.

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Study Aim

The aim of this study is to identify key issues that affect day-to-day practice in dialysis and transplant settings using narrative accounts obtained from a national sample of nephrology social workers.

METHOD

Study Design

A cross-sectional survey research design was used to assess salary, caseload, and other job-specific issues of nephrology social workers. For the purpose of this article, only narrative comments provided at the end of the survey were used to address the study aim.

Respondents

Twenty-seven percent ($n = 406$) of the 1,495 social workers who responded to the CNSW online survey provided narrative comments that were used for this qualitative inves-

tigation. The majority of survey respondents were women (90.6%) and worked in a dialysis-only setting (89.4%). The sample consisted of 88.1% whites, 6.4% Black/African Americans, 3.0% Asian Americans/Pacific Islanders, and 2.5% biracial individuals (Native American and white, African American and white). The respondents' mean age was 46.9 (standard deviation (SD) = 11.9) years and their mean length of nephrology social work practice experience was 8.9 (SD = 7.2) years. Most of the social workers were employed 32 to 40 hours per week (81.2%), with 61.6% working a standard 40-hour work week. See Table 1 for a demographic comparison between the subsample of respondents who provided narrative comments and the total sample. This study received Institutional Review Board (IRB) approval and was conducted in accord with the guidelines on evaluation and research described in the Code of Ethics of the National Association of Social Workers (NASW, 2008).

Table 1. *Sample Demographics*

	Narrative Responses <i>n</i>	Total Sample <i>N</i>
<i>N</i>	406	1495
Age (M, SD)	46.9 (11.9)	47.1 (11.6)
Nephrology practice experience (M, SD)	8.9 (7.2)	8.8 (7.4)
Female (%)	90.6	91.0
Race (%)		
White	88.1	85.7
Black/African American	6.4	9.6
Asian American/Pacific Islander	3.0	2.9
Biracial	2.5	1.8
Hispanic (%)	5.7	6.8
Primary work setting (%)		
Dialysis	89.4	92.3
Dialysis/Transplant	4.2	2.7
Transplant	3.9	2.9
Other	2.5	2.1
Hours worked per week (%)		
< 20 hrs/wk	3.7	4.0
20–31 hrs/wk	15.1	16.3
32–40 hrs/wk	81.2	79.7
40 hrs/wk exactly	61.6	62.9

Note: “40 hrs/wk exactly” represents a subset of the 32 to 40 hrs/wk category. Mean (M) and standard deviation (SD) are reported in years.

Measure

The 2010 CNSW Salary and Caseload Survey was comprised of 130 open- and closed-ended questions that assessed social work respondents in the following domains: demographic characteristics, work environment issues, caseloads, hourly wages, professional tasks, job satisfaction, emotional exhaustion, workload demands, and negative affectivity. The survey took approximately 25 minutes to complete.

Data Collection Procedure

The survey instrument was conducted online by the NKF between March 21 and June 21, 2010. NKF distributed announcements about the survey to its CNSW membership via a membership email listserv, which reaches the majority of CNSW members. The announcements included information about the study aims, instructions on how to access the surveys and requests to distribute the announcement to other nephrology social workers. Prospective respondents were informed of the confidential and voluntary nature of the survey and all participants received a summary of results as an incentive. All data were initially sent to NKF and housed on their secure server prior to their release for statistical analysis. Once the data were de-identified by NKF staff (i.e., by removing email addresses and other information that could potentially reveal the identity of an individual respondent), the first author (JRM) received them in an Excel spreadsheet. All the data sent to the authors are stored on a secure network at Boston University.

Data Analysis

Narrative data from written comments provided in an online survey were analyzed using a grounded theory methodology (Strauss & Corbin, 1990). This methodology consisted of a constant comparative approach to identify concepts and develop categories that provide a structured framework for organizing the data.

Open coding. Both authors read the narrative comments and independently developed a list of concepts and categories for the data. A line-by-line coding approach was used to examine the text, and the authors compared their lists in order to generate a comprehensive and unduplicated list of categories. This list was used for the second stage of coding.

Axial coding. After open coding was completed, categories were collapsed using axial coding. This coding procedure consists of specifying the causal and intervention conditions, context, action, and interaction during open coding (Strauss & Corbin, 1990). The authors identified four themes associated with the implementation of the 2008 Conditions for Coverage for End-Stage Renal Disease Facilities (Federal Register, 2008).

RESULTS

Implementation of the 2008 CfC, which ensure the health and safety of people who require dialysis or a kidney transplant as a life-saving intervention, to some degree has changed nephrology social workers' day-to-day responsibilities and priorities. The findings presented below describe four key themes that emerged from 406 narrative responses provided by social workers who responded to the 2010 CNSW Salary and Caseload Survey. Each of these themes is directly related to the new CfC in that they articulate personal accounts of how these regulations have influenced the priorities, organizational expectations, and ethos of the nephrology work environment.

Increased Paperwork Expectations

Respondents presented strong and compelling evidence of how the new 2008 CfC have substantially increased the amount of paperwork that is now required in order to meet federal regulations. According to some respondents, there seems to be a disconnect between the provider's wish to deliver excellent patient care and the decisions it makes to provide such care. One social work respondent express this disconnect as follows:

[The] Conditions for Coverage have complicated the work environment. My company is now focused on the census of units rather than tasks that need to be performed, even cutting secretarial time based on census. This does not make sense to me. . . . They stress ultra care for patients but the patients receive less time than the paperwork needed to support the requirements for the Conditions for Coverage.

In some cases, social workers reflected on how priorities have changed over the course of their careers as nephrology social workers. One practitioner responded: "When I started this job (23 years ago), I spent 90% of my time with patients. Now, I probably spend 90% of my time with paperwork." The time-consuming nature of completing paperwork is clearly a concern for the respondents as evidenced in the following narrative:

With an ever-increasing demand for numbers and productivity by my employer, I have less time to spend with my patients and meeting their needs. I already spend at least 80%+ on clerical and paperwork requirements, which is very trying for me as a professional. I do not see it getting any better!

Loss of Patient Contact

One significant and alarming consequence of spending more time on paperwork and less time on patient care is the lack of opportunities to cultivate supportive and therapeutic relationships with patients. Respondents often expressed frustration with their employers because they lack an understanding of the volume of work required of social workers to meet Centers for Medicare and Medicaid Services (CMS) expectations.

I do not feel that my employer appreciates how much CMS requirements have added to my everyday tasks. The corporation also has other projects that always seem to fall on the social worker and dietitian to complete, in addition to usual tasks and responsibilities. I believe that tracking the transplant log monthly, reviewing records for incoming patients, being involved in insurance issues, completing applications for financial assistance programs, and [other] clerical tasks when the administrative assistant is too busy, keep me from spending quality clinical time, including meaningful care planning, with my patients.

In addition to a poor understanding on the part of employers of the enormity of mandated work that comes with the new CfC, social workers must contend with the burden of getting everything done and doing so with little public acknowledgment of their demanding work tasks. The following social worker describes the breakdown in how little time she spends with patients and how disclosing this problem does not seem to be an acceptable option.

I feel that the workload and increased responsibility for insurance issues has really grown. Since [the] Conditions for Coverage [were implemented], I have not been able to spend time with my patients as I did in the past. I am drowning in paperwork. Since I do the insurance, travel, transportation, and other tasks required (“give it to the social worker”) and [have] a 1:135 ratio, the time to really get to know all the patients no longer exists. I used to love being a Nephrology Social Worker, but now sometimes it’s just a job that I can’t wait to retire from. I really miss just sitting down and talking with patients on a daily basis. Now it’s more about putting out fires and meeting the Conditions for Coverage. Most of the social workers I talk to feel the same way, but most of us would never admit it in public.

For years, increasing caseloads has been an area of much concern among nephrology social workers (Merighi & Ehlebracht, 2002, 2004a; Merighi et al., 2010). This concern is magnified given new CfC requirements, such as having to complete and score a Kidney Disease Quality of Life (KDQOL) survey for each patient on an annual basis. The narrative below highlights how increasing caseload size contributes to limited patient contact and opportunities to provide quality psychosocial services.

Social work ratios were increased from 1:100 to 1:135 AT THE SAME TIME as the new Conditions for Coverage. [It was] very demoralizing to hear the LDOs [large dialysis organizations] talk quality publicly at the very same time they are cutting clinical services to patients. Specifically, my caseload went from 1:110 @ 1 clinic to 1:160 @ 2 clinics. My charting and KDQOLs get done, but direct patient counseling time has gone down substantially. [It] feels to me sometimes that my LDO is in “a race to the bottom.”

Workload Demands

Social workers in nephrology settings experience many workload demands as a result of factors such as patient acuity, corporate expectations, federal regulations, and caseload size. One respondent summed up very well the demands of a nephrology social work career: “I love my job....there is just a little too much of it!” The range of responsibilities for social workers is vast and often complex, as described below:

I find the enormous scope of the social work role to be the most challenging aspect of social work in a dialysis facility. We are asked to solve so many different kinds of problems in so many different spheres of patient care, some simple and some enormously complicated. Many problems referred to us are not simple to solve, and often require strong problem-solving skills. It often feels as if I am working on too many complex problems simultaneously, [along] with the more predictable tasks of dialysis social work. That creates the feeling of having to work “fast,” though not necessarily “too hard.”

In addition to the complexity of work that is expected of nephrology social workers, some expressed concern about how the demands of their job adversely affected the quality of their work. The two narratives below underscore how a demanding workload affects the quality of their service:

“Since the Conditions for Coverage and in preparation for bundling, I feel that my work performance has gone down and my workload/expectations have increased. The Conditions for Coverage [are] meant to improve patient care, but ... I believe it has actually caused it to decline. The demands are unrealistic, and we cannot keep up the pace. Something has to change before the whole industry is in crisis.”

“There should be a caseload limit of 75–100 patients per social worker. There are not enough hours in the day to adequately perform the duties of a dialysis social worker when the caseload exceeds that number. I have approximately 2 1/2 years experience working in a dialysis setting, including a 50-patient caseload and a 100-patient caseload. I currently have 135+ patients and am unable to do what CMS requires. It is impossible.”

Finally, workloads that are demanding, due to caseload size or task complexity, make it difficult for social workers to complete all mandated assignments, thus increasing the likelihood that they will be out of compliance with CMS regulations when audited by CMS surveyors. As one respondent stated:

Since the Conditions for Coverage became effective, I’ve been behind in psychosocial assessments and KDQOL surveys, thus [I am] fearing an audit of my documentation. Much of my time is spent on insurance issues that could be handled by an insurance specialist (no MSW skills needed) and some of which [are] purely clerical.

Job Dissatisfaction

There are many reasons social workers may elect to end their job or shift to another practice domain. Overall, a national study of dialysis social workers conducted in 2003 reported average-to-high levels of satisfaction for the majority of respondents (Merighi & Ehlebracht, 2004a). In the current study, however, the authors found some social workers cited the CfC as their reason to either terminate their positions or consider ending their work as nephrology social workers in the future. The three quotes below address the issue of the CfC as a motivating factor to end, or contemplate ending, their positions.

“I have just resigned a year and a half before I planned to do so due to the increased workload from the Conditions for Coverage, increased census, reduced secretarial support, [and] inefficient processes that are redundant-to-ridiculous. The balance between the amount of counseling and clerical work I am required to do is very one-sided.”

“I am making plans to complete my LCSW and seek other employment. I believe this is an unhealthy environment to work in long-term. It is too much stress; the demand is too great with all of the corporate programs coupled with all of the clerical duties. The corporation is too devoted to the bottom line. I am not afforded enough time to adhere to the Conditions for Coverage and am in a constant battle to meet the demands.”

“I understand and appreciate what the Conditions for Coverage are and why [they exist], but management has to . . . give social workers the time to do quality work, rather than just do mediocre work to satisfy the auditors or meet number goals. Because I like the social work part of the job and the patients, I stay at my job, but should another position arise where I am given the opportunity to do social work elsewhere, I may take it.”

Positive Views of Job and Work Environment

Although many of the social work responses highlighted concerns and challenges associated with the implementation of the new 2008 CfC, a minority of respondents offered favorable viewpoints regarding their jobs and work environments. Most of these positive responses indicated that managers/administrators were supportive, which helped the social workers handle the job-related challenges associated with CMS regulations. We offer three narratives that highlight how finding support in the workplace can assist nephrology social work practitioners in coping with a complex and demanding work environment and maintaining job satisfaction.

“I absolutely love my job, my patients, my peers, my boss, and my company. I just feel that social work has been demeaned instead of esteemed since the [new] CMS Conditions for Coverage.”

“I am fortunate that I have worked in a clinic for 15 years that is generally well managed, and generally respects the role of the social worker. My caseload of 110 seems very reasonable, compared to some of my peers in other companies who have 150 to 175 patients [on their] caseloads. I also am in a clinic [where] patients are of the income level that their basic human needs are met, and patients that don't have extraordinary complex social problems. I know that this contributes to my long tenure in this clinic and in this social work role. I am satisfied with my position, my salary, and my work environment compared to many of my renal social work colleagues who seem to be miserable in their jobs. Yes, there are non-clinical tasks that I have to do, but I have minimized them over the years by good self-advocacy. My company took away our 401k two years ago but has a small profit sharing [plan]. Compared to others in renal social work, I think I have a very good work situation and am pleased with the opportunities given to me. But all that could change in one day and I would feel differently if that happened.”

“In general, I like my job and get pretty good support from my managers, which makes it easier to complete all that is required of me. I do sometimes feel overwhelmed with paper, and believe I could better serve the patients if the paperwork was more or less streamlined. For the most part, I have very few complaints about my job.”

DISCUSSION

This article focused specifically on the effects of the 2008 CfC as they pertain to day-to-day nephrology social work practice—that is, increased paperwork expectations, loss of patient contact, workload demands, and job dissatisfaction. With regard to increased paperwork expectations, many respondents reported that this task now consumes the majority of their time and diminishes the overall quality of patient care. Although it is acknowledged that paperwork is a necessary component of the social worker's role in the nephrology care setting, the new CfC seem to have created an exponential increase in clerical tasks and jeopardized important opportunities for social workers to develop supportive or therapeutic relationships with their patients. These relationships are an essential part of quality social work practice because they provide the foundation to improving their patients' health outcomes and quality of life. They help patients: adjust to an intensive treatment regimen; engage in effective self-management and self-care; and cope with the social, vocational, and mental health challenges that result from kidney disease. The over-emphasis on non-clinical tasks, such as paperwork, ultimately results in less-than-optimal care for ESRD patients because there is little opportunity for social workers to address their complex psychosocial needs.

One major consequence of spending a disproportionate amount of time completing paperwork is a loss of patient

contact. The survey responses expressed the social workers' concern that limited time with patients feels like an erosion of their practices. Coupled with increased caseload ratios, many social workers commented on how they feel their social work role is poorly understood or unrecognized by their employers, and some believe that they need to perform tasks that support the financial goals of the organization. As one social worker stated, "[It] feels to me sometimes that my LDO is in a 'race to the bottom.'"

Because of the new mandates outlined in the 2008 CfC, social workers are challenged to strike a balance between the fulfillment of these CMS regulations and addressing the complex psychosocial needs of their patients. Limited communication between social workers and patients comes at a cost. For instance, patients may need supportive counseling to address symptoms of depression or other mental health concerns. If the social worker has little contact with a patient or is not aware of changes in a patient's mental health status, the result may be poor adherence to a treatment regimen, a decline in physical well-being, or compromised health outcomes for the patient. Research has demonstrated how nephrology social work interventions can help improve patients' psychological well-being and their psychosocial adjustment (Beder, 1999; Dobrof et al., 2001; McCool et al., 2011; Sledge et al., 2011). It is clear that efforts are needed to educate both employers and patients about the importance and purview of the social worker in nephrology care, and to take positive steps so that comprehensive psychosocial services can be provided in the best interest of the patient.

Workload demands continue to be a major concern for nephrology social workers. Research by Merighi and colleagues has reported on the workload demands of dialysis (Merighi & Ehlebracht, 2005) and transplant social workers (Merighi, Browne, & Keenan, 2009). The narrative findings presented in this article corroborate the quantitative assessment of workload in these specific practitioner populations. What is noteworthy in the current analysis is that the CfC seem to make it very challenging for social workers to satisfy CMS requirements, given that their workloads were already demanding prior to the new federal regulations. Specifically, the frequency of citations by State surveyors for ESRD V tag 552 (V552; psychosocial counseling/referrals/assessment tool; "The interdisciplinary team must provide necessary monitoring and social work interventions. . .") has risen from 21st place in fiscal year 2010 to 11th place as of February 24 in fiscal year 2011 (Witten, 2011). This increase in the number of citations for V552 is likely indicative of the difficulties associated with social workers trying to complete all CfC mandates. More work is needed to understand how increasing demands from the new CfC and social worker-to-patient staffing ratios (Wolfe, 2011) affect patients' quality of care and health outcomes.

Increased clerical demands, loss of patient contact, and mounting workloads can manifest in job dissatisfaction for social workers in nephrology settings. It is evident from the narratives offered that some social workers have reached a limit with regard to the changes that are taking place in nephrology care. It is their perception that limited support and resources available to them make it difficult to sustain a career as a nephrology social worker. Although research on dialysis social workers prior to the 2008 CfC indicated that the majority of social workers reported average-to-high levels of job satisfaction (Merighi & Ehlebracht, 2004a), it is unclear if these levels of satisfaction have been maintained in the new climate of CMS regulations.

In order to provide an evenhanded presentation of the social work respondents' comments, we included a section that articulates positive views of their job roles and work environments. Although we found compelling evidence for the four themes described previously, not all social workers in nephrology settings experience burdens associated with their employer's expectations or the 2008 CfC mandates. It appears that social workers who have positive relations with their management and caseloads that do not exceed the national average tend to have a positive outlook with regard to their job roles and work environments. In particular, support from management seems to buffer the burdens associated with a demanding and fast-paced nephrology care environment.

Study limitations include the cross-sectional research design, low response rate for narrative comments, and selection bias. This investigation used a cross-sectional design, which is common in survey research studies; unfortunately, it obtained information at one point in time and did not capture social processes or change. Social workers may have responded to items based on how they felt on the particular day they completed the survey, and these feelings may not be reflective of how they generally feel. The low response rate for written comments (27%) prevents us from making generalizations to the total study sample or the CNSW membership. However, the demographic profile of the respondents who included written comments is strikingly similar to the total sample (see Table 1). Finally, obtaining participation from only one professional organization limits the external validity of our findings. Also, there may be selection bias with our sample because data on non-respondents are not available. Despite these limitations, this is an important national study of the current concerns and challenges of nephrology social workers in the United States. As such, this study provides important data for future investigations.

Additional research is needed to quantify, in a detailed manner, how the 2008 CfC affect nephrology social workers' day-to-day practices in dialysis and transplant settings. For example, the findings reported in this study point to how perceptions of management may be an important variable in social workers' overall assessment of their job satisfac-

tion and roles, despite having much paperwork to complete and a high caseload. Future investigations should test the degree to which attitudes about management mediate the relationship between job-specific factors such as workload demands or caseload and job satisfaction. Clearly, national advocacy efforts are needed to persuade administrators and corporate employers to allocate more time and resources to social workers so that they can provide much-needed counseling services to their patients. Establishing a healthy balance between meeting federal mandates, employer requirements, and patient needs will take us one step closer to providing optimal care to people with kidney disease.

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